SUPREME COURT, U. S.
FILED
SEP 20 1973
MICHAEL RODAK, JR., CLERK

No. 73-177

In the Supreme Court of the United States

OCTOBER TERM, 1973

GEORGE GOLDSTEIN, RECEIVER OF HOLIDAY NURSING HOMES, INC., PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE UNITED STATES IN OPPOSITION

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OPINION BELOW

The order of the Court of Claims (Pet. App. 10-12) is not reported.

JURISDICTION

The order of the Court of Claims was entered on April 27, 1973. The petition for a writ of certiorari was filed on July 25, 1973. The jurisdiction of this Court is invoked under 28 U.S.C. 1255(1).

QUESTIONS PRESENTED

1. Whether the scope of review over medicare provider reimbursement claims, for periods before June 30, 1973, embraces issues of fact.

2. Whether contractually provided arbitration remedies must be exhausted prior to review of medicare provider reimbursement disputes.

STATUTES INVOLVED

Section 1816(a) of the Social Security Act, 42 U.S.C. 1395h(a), provides in pertinent part:

> If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization (subject to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers, and for the making of such payments by such agency or organization to such providers. * * *

STATEMENT

1. In December 1966, Holiday Nursing Homes, Inc. ("Holiday"), the original plaintiff in this action,[1] was approved as a provider of medicare services under the Social Security Act, 42 U.S.C. 1395, *et seq.* Thereafter, Holiday filed with the Secretary of Health, Education, and Welfare, and the Secretary accepted, its agreement under which it would be paid the "reasonable cost" of medicare services it provided. See 42 U.S.C. 1395x(v), 1395cc(a); 20 C.F.R. 405.401, *et seq.*

Pursuant to 42 U.S.C. 1395h(a), Holiday and the Secretary agreed to the designation of the Blue Cross

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[1] In October 1972 George Goldstein, the receiver of Holiday and petitioner herein, was substituted as the party plaintiff.

Association as Holiday's fiscal intermediary; in accordance with this agreement, Blue Cross was authorized to determine, *inter alia*, the amount of the payment to which Holiday was entitled for the medicare services it provided.

In 1968 Blue Cross, with the approval of the Secretary, adopted an appeals procedure for the settlement of disputes concerning payment determinations. This procedure provides for a full evidentiary hearing before the Blue Cross Appeals Committee on any appeal from an initial payment determination adverse to the provider of medicare services.

2. Upon audit of Holiday's cost reports for the periods 1967, 1968, and 1969, Blue Cross initially determined that Holiday's reasonable costs under the medicare program were $179,970 less than the amount already paid for these periods. Holiday contested these determinations, claiming that it had been underpaid a total of $187,077. Holiday appealed the determination for 1967 to the Blue Cross Appeals Committee, which affirmed the denial of Holiday's claim. Holiday did not appeal the determinations with respect to 1968 and 1969.

Holiday then brought the present action in the Court of Claims, seeking judicial review of the Blue Cross cost determinations for all three years. In addition to its original claims for those years, Holiday claimed $362,000 for consequential loss of property, thereby requesting a total judgment of $572,077. The government moved for summary judgment, contending that medicare provider reimbursement claims are not subject to judicial review and that the claims for 1968 and 1969 were in any event barred by Holiday's failure to exhaust the available appeal procedures.

In an order issued April 27, 1973, the Court of Claims dismissed petitioner's claims for the years 1968 and 1969 for failure to appeal the fiscal intermediary's initial payment determination to the Blue Cross Appeals Committee. The court further held that the denial of petitioner's 1967 claim was subject to judicial review but that the scope of review was limited to nonfactual issues, *i.e.*, to a determination whether the procedures employed by Blue Cross and the decision of its Appeals Committee were constitutionally valid and complied with the governing statute. Accordingly, the court remanded the 1967 claim to its trial division for consideration of those issues.

ARGUMENT

1. The order remanding the 1967 claim for trial is not a final order; petitioner has shown no compelling need for review of this interlocutory order and we see none. See, *e.g.*, *American Construction Co.* v. *Jacksonville Railway*, 148 U.S. 372, 384. See also Rule 20 of the Rules of this Court. Moreover, contrary to petitioner's contention (Pet. 9), the scope of review granted by that order is consistent with that exercised in *Aquavella* v. *Richardson*, 437 F. 2d 397 (C.A. 2); the review granted there, as in this case, extended only to claims that the Secretary had acted "without statutory authority and in a manner that violated due process." 437 F. 2d at 399. Indeed, the court below correctly indicated (Pet. App. A, p. 11) that it was following *Aquavella*.[2]

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[2] Petitioner also contends that the decision below conflicts with *Cappadora* v. *Celebrezze*, 356 F. 2d 1 (C.A. 2). That case held that the Secretary's denial of a request to reopen administrative consideration of a claim for mother's and child's insurance benefits was reviewable, but that the denial of the request to reopen was not an abuse of discretion. The case did not involve review of a medicare provider reimbursement claim.

Furthermore, the statutory scheme relating to providers of medicare services has been significantly amended by Section 243 of the Social Security Amendments of 1972, 86 Stat. 1420. Under that provision, a provider may appeal an adverse reimbursement determination by its fiscal intermediary to an administrative board, whose members are chosen by the Secretary; the decision of the board is final unless reversed or modified adversely to the provider by the Secretary; the Secretary's decision is itself subject to judicial review. This new procedure will apply to reimbursement disputes involving more than $10,000 for accounting periods after June 30, 1973. Thus, although the potential claims for prior accounting periods may be substantial, in the absence of a conflict the issue presented by this case does not warrant review by this Court.

The decision denying review of factual issues is in any event correct. The fiscal intermediary, in determining factual issues such as the reimbursable reasonable costs incurred by a provider of medicare services, is acting in the capacity of an arbitrator under the contract between the provider and the Secretary. See *Schroeder Nursing Care, Inc.* v. *Mutual of Omaha Ins. Co.*, 311 F. Supp. 405 (E.D. Wisc.). There are no contractual or statutory provisions (other than those recently enacted with respect to accounting periods after June 30, 1973) for judicial review of the factual determinations made by such an independent arbitrator. Having agreed to submit its contract claims to the arbitration of the fiscal intermediary, petitioner should be bound by that intermediary's findings, at least where those findings are made under proper procedures and conform to the pertinent statutory requirements. See generally Jalet, *Judicial Review of Arbitration: The Judicial Attitude*, 45 Cornell L. Q. 519,

532-542 (1960).[3] The court below has fully protected petitioner's interests by remanding its claim for a determination whether the intermediary employed proper procedures and met all statutory requirements.

2. The court below properly dismissed petitioner's 1968 and 1969 claims for failure to exhaust the available appeal procedures. The decision of the fiscal intermediary, which petitioner contests, was subject to review by the Blue Cross Appeals Committee; that committee's action on appeal could have resulted in full satisfaction of petitioner's claims, obviating any need for judicial review. Exhaustion of such contractually provided arbitration remedies should be required as a matter of judicial economy. See *Bumb* v. *Hospital Service of Southern California,* 440 F. 2d 1077 (C.A. 9). Cf. *McGregor* v. *Hogan,* 263 U.S. 234.

CONCLUSION

For the foregoing reasons the petition for a writ of certiorari should be denied.

Respectfully submitted.

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SEPTEMBER 1973.

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[3] Petitioner's "substantive rights derive solely from the contract." *U.S. Bulk Carriers* v. *Arguelles,* 400 U.S. 351, 361 (concurring opinion of Harlan, J.). Thus, unlike *Alexander* v. *Gardner-Denver Co.,* petition for a writ of certiorari granted February 20, 1973, No. 72-5847, this case does not involve a statutory claim arising independently from the rights created by contract.

DOJ-1973-09